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The Gendered Body in Family Planning in Indonesia

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Abstract
This paper analyses the experiences of women under the family planning program in Indonesia based on interviews. Indonesian family planning program (called KB, an abbreviation of Keluarga Berencana in Indonesian) developed in line with successive five-year developmental plans under the strong authority of the government with much success. Women suffered many side effects of hormonal contraception when first taking them, which they accepted as necessary steps to acquire proper wives' bodies. KB program's exclusive focus on women means that it is not a neutral contraceptive service to everybody, but a method of monitoring women's fertility. By disseminating ideas of how men and women should be in their reproductive period and through its actual practice, KB constructs gendered body and gendered living in Indonesia. Also KB both undermines and promotes women's empowerment depending on the way it is provided to women.

Keywords: family planning, empowerment, gender, Indonesia, reproductive health
Introduction

In Indonesia, family planning is called KB, shortened from Keluarga Berencana; it has been a mainstay of each of the government’s five-year-plans which started in 1969. The success of the Indonesian family planning program is widely recognized, with statistics showing a continuous decline in total fertility rate from 6 in 1969 to 2.78 in the mid-1990 and then to 2.37 in 2012. While the factors contributing to this fertility decline are numerous and need to be examined from many aspects, the most significant include availability of contraception, a development-oriented government bureaucracy, economic changes, the rise of a middle-class, and the changing roles of women, all of which are closely inter-related (Hull 1987). However, the one feature which is credited as having the most influence on this rapid decline in fertility is the vigorous way in which, the government mobilized the network of female volunteers as a driving force (Utomo et al 2006). There has generally been an assumption that family planning programs contribute to women’s empowerment by giving them power to control their fertility (Ringheim 1996, Herarti 2004). However, whether an exclusive focus on women, as in the Indonesian program, does indeed lead to women’s empowerment needs to be examined (Sciortino 1998).

This article recounts from interviews women’s experiences of Indonesian family planning (KB) and argues that KB had both positive and negative impacts on women’s empowerment depending on the context in which it was practiced. Also, I argue that this family planning program constructs the male and female body differently in its application, especially by transforming a woman’s body to a normative wife’s body.

Development of the program

In the first phase (1969-73) of the government five-year-plans, the family planning program focused on the islands of Java and Bali where the populations were dense (Warwick 1986:454). In 1970 the BKKBN (Badan Kependudukan dan Keluarga Berencana Nasional), an organisation responsible for family planning and family welfare, was set up by the national government; it became the powerful engine of this program.

Under the second plan (1974-79), implementation was extended to ten new provinces besides Java and Bali and village contraceptive distribution centers were set up along with local supply centers for contraceptives and medical support (Warwick 1986: 455). This was because, by 1975, many new users were adopting the pill rather than the IUD. This required the authorities to maintain pill supplies and remind women to continue to use contraception, whereas the IUD needed no such resupply once it was put in place.
in the clinics (Shiffman 2002: 1203). Despite this, women’s preferences were largely for contraceptive pills so village family planning groups were developed to ensure their supply, along with condoms, and to maintain continued use among village women by exerting peer pressure. These groups were successful in spreading the KB programs to all local women by using such strategies as calling on the authority of the village head, or combining KB with other activities like the rotating credit association (arisan), a popular women’s socializing activity in Indonesian villages, and other methods.

Under the third plan (1979‒84), the program was geographically extended and the proportion of eligible couples using family planning services rose from 2.8% in 1971‒71 to 62.2% in 1984‒85 (Warwick 1986:462). By this time, Indonesia under the Suharto government had made considerable progress in its development reflected in economic growth, improvement in health, increase in opportunities for education and other factors. The government’s aims in trying to combine the benefits of economic development with family planning is exemplified by an official Indonesian family planning slogan, “The small, healthy, prosperous family”, which clearly implies the idea that small families make a prosperous society.

**Effectiveness of the program**

Warwick, in writing about Indonesian family planning, states that the best single predictor of contraceptive use was the sheer number of people working to implement it (1986:462–463). This focus on the number of people mobilized to implement the program was emphasized in the address by Haryono Suyono, then the head of BKKBN and the minister of Population Ministry, at the meeting of the Population Association of America in 1994. He stated, “The National Family Planning Coordinating board of Indonesia was created over two decades ago to ensure that every couple has access to contraception, and that every child is born as a wanted and planned child.” (1994:2).

He continued by saying, “In the first stage, we were primarily concerned with getting as many people involved as possible, as rapidly as possible, as widely dispersed as possible. We recognized that quality…would initially have to be a secondary concern” (1994:4). This statement clearly shows that initially family planning was focused on large numbers of acceptors, on the quantity rather than the quality of the program. The number of acceptors was further increased by engaging the nationwide organization of women’s volunteer groups, PKK (Pembinaan Kesejahteraan Keluarga), into the program. The group members acted as both as acceptors of contraception and workers implementing the program by recruiting new members and ensuring existing members stayed in the group through application of peer pressure. The power of PKK comes from the nature of its organization where a woman’s status in the group is a reflection
of her husband’s social position. This led to a hierarchy of status extending from the central government, down through provincial government to the village level in which a village chief’s wife becomes the local head of PKK. By relying on PKK, the program was able to establish a route connecting central government policy to the village level and so to women at grassroots level. Shiffman states that by engaging the PKK, it was as if the BKKBN lengthened its arms tenfold, enabling it to reach into village society even more deeply (Shiffman 2002:1208).

Another effective factor was that the program was combined with other developmental plans which looked attractive to the people. Moreover, the BKKBN strategically used incentives to increase numbers of acceptors. Haryono Suyono states, “at the beginning of modern family planning programs, the terms ‘birth control’ or ‘family planning’ had to be hidden by euphemisms; often programs were labelled ‘family welfare’ when, in reality, their only goal was to increase contraceptive use.” He continues by saying, “in order to be sustainable, family planning programs really should be linked with other activities designed to improve people’s health, education, economic situation, environment, etc., i.e., their ‘family welfare’. …… that if they became fp ‘acceptors’, their lives would improve” (1994:21). This is a very explicit message to justify the use of incentives and the combination of contraceptive use with other attractive programs. For example, in 1979 the BKKBN introduced funding for income generating activities such as purchasing animals, opening of shops, and others; eligibility for funding the many groups that were established was dependent on being on family planning for a specific period of time (Shiffman 2002:1209). Warwick also states that one unique element of the Indonesian family planning program was the integration of its service with other developmental programs such as family welfare education, family nutrition programs for children under five, and income generating activities (Warwick 1986:472). He also mentions that integrating the program with other medical services or with nutrition programs was useful in overcoming the embarrassment and shame many couples initially felt about the idea of family planning. By doing so, it promoted a popular view that family planning is a natural part of daily life and a normal activity of the government (Warwick 1986:469).

Of the other factors that contributed to the success of the program, political support was important. The BKKBN could operate through the authoritarian political system backed by President Suharto who gave it enormous power and support. Suharto attended ceremonies, posing for pictures with BKKBN officials, made statements to the press supportive of the program, and continued to provide a generous budget to the program even when government revenues were falling (Warwick 1986:455).

These were the overall developments and factors surrounding successful implementation of the program in Indonesia. It is described as successful because the
main aim of reducing fertility rate was accomplished in a relatively short period of time, particularly considering it is a predominantly Muslim country. However, how women, the main acceptors of the program experienced it and how it was evaluated from their perspective remains to be examined.

Research in Pontianak, West Kalimantan

The research was conducted from 16th to 26th August in 2009 in Pontianak, West Kalimantan. In preparing for the research, I asked a research assistant to collect married women and men with children for group interviews. In the end, 40 women and two men had been organized into ten groups (group A to K) when I arrived to start the interviews. Apart from these people, two bidan (licensed midwife), two nurses and two dukun (traditional birth attendant) were interviewed either separately or in groups. The list of 42 women and men is shown in Table 1. The youngest woman was 17 years of age and the oldest was 46 while the number of children ranged from 1 to 5. Group E and F consist of young mothers, most of whom became pregnant unintentionally in their high school years.

Interviewing was conducted in the Indonesian language for two hours each session and consent for recording was obtained before each meeting. Some women in the groups knew each other but others had never met before. Once the conversation started with the help of an Indonesian interpreter, the women felt easy talking about their experiences of KB. Only when I felt the need to change the course of conversation did I interrupt by asking questions to the interpreter who would then introduce a new topic to be discussed. In this way, interviewing continued without pauses, with the women sometimes asking me questions and taking interest in the contraceptive methods of the Japanese and the reasons for widespread use of condoms in Japan.

Overview of Pontianak and West Kalimantan

Pontianak is the provincial capital of West Kalimantan with a population estimated to be 700,000 in 2007. The province has a population of around 4,120,000 people, with 62% working in agriculture, 14% in selling goods, 10% in service industry, and 3.7% in construction (Kalimantan Barat in Figures 2008:70). Regarding the level of education in West Kalimantan, 80% have less than junior high school equivalent, 15.8%
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Table 1. List of interviewed people

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graduated from high school and only 4.2% have a university degree or higher education of some sort (Kalimantan Barat in Figures 2008:83). The ethnic composition of West Kalimantan is very mixed, as is shown in Table 1.

In Pontianak in 2007, the most popular method of contraception for new recruiters was injection at 47.7%, then the pill 38.4%, IUD 7.4%, surgery 2.8%, condom 2.7% and implant 0.95% (Kalimantan Barat in Figures 2008:131‒132). These figures show that while injection and the pill were popular among women at this time, the figures change frequently as women switch methods often, as shown below.

**Research result**

The Women in the research group talked about KB without any hesitation or embarrassment in the same way as they talk about their children’s immunization. Some women said they had experienced failure while they were on KB or when switching the method of KB, resulting in pregnancy. The women in group E are young mothers who had become pregnant while in high school. They said that sex education was provided briefly at high school but they had never seen real contraceptives nor had been given instruction on how to use them. There is a wide gap between married women and young unmarried women concerning the amount and kind of contraceptive knowledge provided to them. Most women start KB 40 days after giving birth to their first child. The women are told to come back to Puskesmas (community health center) for immunization of their baby and then given a choice of KB they will use thereafter.

In the following section I will illustrate women’s experiences of KB based on four points: side effects and switching of KB, the condom as not for KB, folk beliefs affecting KB and control of women’s bodies and KB as a necessity.

**Side effects and switching of KB**

Women, having started KB, continue with it even if they experience many side effects. KB is considered to be a normative practice for married women and they feel obliged to get accustomed to it despite considerable bodily discomfort.

(The shortened name, in parenthesis, of each person from Table 1 follows the comment.)

'I started taking KB from 40 days after birth. When I took three-months injection, my weight changed from 59kg to 65kg. So I switched to one-month injection and I could lose 1‒2kg.' (Ret)

'You go for immunization 40 days after birth. Then you are given KB, too. I used three-
month injection for three years and gained weight. I was slim, just 45kg but now I weigh 62kg. I don't have period every month but my appetite is normal. For me it's all right to gain weight but injection makes me lose sexual drive.' (Hal)

Although side effects are both uncomfortable and stressful, women regard them as necessary steps towards adjustment and do not see them as health hazard. Medical doctors and bidan who provide them with KB look at bodily symptoms as adaptive processes and do not give them serious consideration. One midwife even suggested that if there were no side effects, it must be because the KB was not working properly.

'I used one-month injection for a year and then bidan told me to switch because she thought that it was not working, as I didn't gain nor lose weight.' (Mar)

'I started KB 40 days after birth. I use three-month injection now. They said I had no side effects but I have a headache. But it is OK if I take medicine. I get medicine from bidan. First I was on one-month injection but kept bleeding, so I switched to three-month one. I think side effects are the signs that my body is trying to adapt.” (Yes)

Interpreter “Do you go to bidan when you have side effects?’

'No, I don't, because bidan had already told me that menstruation would become irregular.’ (Im)

'It is natural for KB beginners to have side effects such as headache, nausea, bleeding. It will be about three months until they get adapted.' (bidan 1)

Interpreter “After three months do symptoms go away?

'It depends on each woman. If her body adapts to hormonal contraceptives, it will be OK. Some do not have any side effects, others a little and if symptoms are severe, I tell them to switch. For instance, if bleeding continues for 14 days, women will develop anemia.’ (bidan 1)

Women having side effects can only switch KB, as withdrawing from it is not believed to be possible. If the effects are too severe to bear, the women are advised to move on to a different kind of contraception. If all those fail, there is the final option of the condom.

'When I was on injection, I got very fat so I changed to pills. Then I developed high blood pressure, so I moved back to injection. But then I had menstruation all the time for three months. Then the blood became black and I went to Puskesmas where they told me to change to pills again.’ (Jum)

'First I used three-month injection and I did not get menstruation, only once in 6 months 

2 There is some research on male contraceptives (Purdy 2006, Solomon et al 2007, Oktaviatie 2010)
I got only a little blood. It was like this for 10 years and then I changed to monthly injection but then my menstruation did not stop. So I changed back to three-month one for one year and then changed to pills.' (Mul)

As is stated in other articles (Hardon 1997, Fathona 2000), the inconvenience of side effects is the principal reason for women to switch KB. Their search for the right KB continues for months and even years because having symptoms indicates that their search is not yet complete.

**Condom is not KB: KB is for women**

Women look at KB as their obligation and do not expect their husbands to take KB even when their own side effects are severe. Married women all agree that they need to learn to control their fertility with the use of KB.

Interpreter “Don't you expect your husband to be on KB?”

'I asked him about a possibility and he said ‘Where in the world a man would do KB?’ My husband said he wouldn't have vasectomy nor use condom. So I have three-month injection.' (Nun)

Interpreter “Don't you think a man should have KB, too?”

'What do you mean? It’s a new idea that a man takes KB’ (Rah)

Others 'Condom is not new.'

'No husband in this area would have KB' (Evy)

'Bidan does not talk about condom. She only explains to women' (Rah)

The condom is not considered to be a proper contraceptive method for married couples because if a wife is on KB, there is no need for a husband to use contraception as long as sex takes place within marriage. Having experience of condoms, in turn, alludes to the possibility that a husband has sex outside of marriage.

Interpreter ‘Do you ever talk about condom use with your husband?’

'If a man buys a condom, people are suspicious how he will use it. Condom has a negative image. We don't normally think a man uses condom with his wife.' (Evi)

'If you are seen buying a condom, you are given a strange look. People may think you are having a free sex just like a teen age kid. If a husband buys a condom, we suspect that he might use it with other woman.' (Mar)

'I watched on TV that there are varieties of condoms with different kinds and tastes. So
I took interest. But neither my friends nor my husband want to buy them. My husband said ‘No’, after he used it once, saying he feels different. So I don’t want to use it. I want to use what is good for both of us.’ (Hal)

Husbands in the interview deny any thought of using condoms. Asking about condom use is tantamount to asking about sex with other women.

Interpreter ‘Do you know about condoms?’
‘I don’t know anything about condoms. I know the name condom, though.’ (Ded)
‘I saw on TV and heard from friends. Condom is something to prevent sexually transmitted disease.’ (Hab)
Interpreter ‘Did you ever think of using condoms?’
‘No, never. I only have sex with my wife.’ (Hab)

Folk beliefs affecting KB and bodily management with the use of KB

Women develop a range of images of different KB based on their own and on other women’s experiences. They try to manage their bodies with the use of different KB and with knowledge they gain through experience.

‘I heard pill gives strong sexual appetite’ (unknown)
‘I heard injection dries up your uterus’ (unknown)
‘I can’t use IUD because IUD is not suitable for those who have heavy work. If you carry something heavy, IUD may drop. Women in urban areas can use it because they don’t work hard.’ (Yes)
‘There are many different kinds of pills; 5000, 10000, 15000 and 30000 (Rupias) per month. Color also varies, red and yellow. Some can be used while breastfeeding. The most expensive kind do not give you pimples and cheap one will give you nausea and headache. Some pills even cost 90000 and 140000 and these won’t give symptoms to your body. It depends on how much you can pay.’ (Mel)
‘The second child was born because I forgot to take pills. When the baby was born it had many pills over its body and so the baby didn’t cry.’ (Har)
‘I heard from another person that this woman was on three-month injection and when her baby was born, it had marks on the body. This was caused by needles of the injection. IUD is not good if you ride a motor bike, because it may fall out.’ (Hal)

Women try to control their bodies by making use of hormonal changes brought about by different KB. They try to keep a balance between the effects of one KB and those
of another. After some years, they overcome the difficulties experienced in early KB use and manage to control their fertility by skillfully combining the characteristics of each method of KB to attain their aims. Paradoxically the pill and one-month injection are considered to make women fertile despite being contraceptives, and are taken to become pregnant.

'Injection makes me fat. So I switch from injection to pills two days before I need to have another injection. After some time on pills, I change to injection again and I can keep my weight 55kg constant.' (Mah)

'If you want to get pregnant for a long time, you must bait pregnancy by switching to pills.' (Net)

'I didn’t have menstruation when I was on three-month injection. I wanted to have one more child and bidan said to me you need to bait pregnancy if you want a child. She said to change to one-month injection and I got pregnant.' (Hal)

'When I went to Puskesmas and said that I want to have one more child and I don’t want to take KB, bidan told me to use condom.' (Mel)

While it is irrational to take the pill, have injection or use condoms to prepare for pregnancy, these remarks illustrate the belief that married women should always be on KB even when they want to get pregnant or when they are breastfeeding. The bidan also advise women to switch to the KB method that will make their bodies most fertile.

**KB is a necessity**

Family planning in Indonesia was largely forced on communities in a top down manner at the early stage of its implementation. However, the people now regard it as a necessity to control the number of children.

Interpreter “Would you be on KB even if the government abolished KB policy? ‘Of course, how can I limit the number of children without it? (Mar)

“Having many children is too much trouble because of economic situations. Global economy is very unstable.' (Ret)

’In my mother’s time, people said, "banyak anak, banyak rejeki (many children, more luck)" but now "banyak anak, banyak susah’(many children, more problems)". Before there was no expensive things. The old times were easy. We could plant vegetables and ate them. Nowadays everything needs money. No money, no food. Before there was no shopping mall. Now once a week children go there and spend money. What would someone do, if she had 10 children?’ (women in group B)
The two men in this interview were both engaged in selling goods. Ded sells goods from a boat to upstream villages, which takes him away for about a month for each journey. Hab sells accessories in the bus. Both got married young and have one child.

Interpreter 'If the government canceled KB campaign, would you still practice KB?'
'If I stop KB, I would have countless children. Children nowadays are different from children before. Now there are many expensive things. In the past, just rice and vegetables were OK but now food has much more variation.' (Ded)
'Yes, I would practice KB. Nowadays the economy is difficult. With many children, it is very difficult. Children these days do not want such jobs as construction work or selling things. So most of them just hang around on the street, go home, eat and hang around again.' (Hab)
Interpreter 'What kind of education do you want for your children?'
'Get a high education so she can get a job. Being a civil servant or something.' (Hab)

It would not be incorrect to deduce from these comments that people are now willing to take KB on their own, without outside enforcement or peer pressure from the community. It is, however, ironic that people want KB not because they actually feel the benefits of a smaller family, and the wealth that it brings about, but because they no longer feel the richness of life having many children. Lack of hope for the future and a sense of uncertainty force people to protect themselves by limiting their number of children.

Discussion

Constructing gendered body through the practice of KB

In Indonesia, family planning is focused mainly on women, specifically married women, releasing men from the responsibility of controlling their fertility. This exclusive focus on married women, although disproportionate from gender perspectives, can still function as long as sex is confined to marriage. In order for a wife to fulfill the goal of controlling her fertility, she moves from one method of KB to another until she finds one that causes her the least problems; this process she accepts as a necessary adjustment to acquire a wife's body. In this way the practice of KB constructs male and female differently and shapes a woman's body into that of a wife's. It is a body that is sexually active but one whose fertility is continuously monitored directly by bidan and by other health authorities and ultimately by the government. This is illustrated by the fact that women need to be on KB all through their reproductive period, starting from 40 days after birth, continuing during the time of breastfeeding and on, even to when
they want to conceive the next child. Women are advised to use the pill, injection or a condom when they wanted to get pregnant, which means they are never allowed to withdraw from KB in their reproductive life. In this sense, KB is not a neutral provider of information or contraception services to all, but a vehicle of fertility control by the government targeting exclusively married women.

Condoms, in the perspectives of both women and men, are not included in KB but are considered largely incompatible with it. As is shown in Figure 1, condoms are seldom used by married couples and are suggestive of premarital or extramarital sex. KB is provided in a medical context such as the Puskesmas or clinic by a bidan or a doctor, while condoms are bought at markets or convenience stores. KB reflects stable relationships, while condoms imply casual sex. KB is the method of contraception authorized by the government, while condoms have negative, immoral, and dangerous image in Indonesian society.

This attitude to condoms makes an interesting contrast with Japan where condom use by husband is the principal contraceptive method and the use of the pill makes up only a very small proportion of contraceptive use. As the pill is the method taken on women's initiative, to some people it has a negative image, linking it to women's sexual freedom and promiscuity. In contrast, the practice of wives taking the pill in Indonesia is not considered as their having sexual freedom or being promiscuous. Biologically, both genders can use contraceptives but different social meanings are attached to each method of contraception; in Indonesia the condom is linked to male sexual freedom, whereas in Japan the pill is associated with women's sexual freedom.

Does KB contribute to women's empowerment?

Whether family planning in general contributes to the empowerment of women is difficult to answer, as there can be both positive and negative effects depending on the context in which it is provided. In the case of KB in Indonesia, the following conditions need to be taken into consideration: women were experiencing a wide range of health hazards which they were unable to recognize; KB had been effectively forced on the women without the chance to refuse; and KB was disproportionately targeted at women. If it is accepted that the family planning program in Indonesia succeeded as
a result of women’s sacrifices, a natural conclusion would be that KB did not lead to women's empowerment.

However, taking a wider perspective to include future possibilities, women can increase their chances of decision making and of controlling their own lives if they know how to control their own fertility. Already women are now utilizing the effects of hormonal contraception to create the kind of bodily conditions they want. The idea of controlling one’s own fertility, instead of relegating it to nature will widen the women’s opportunities and eventually lead to their empowerment.

Moreover, it is not just women but also men who wish for control over fertility as they anticipate a difficult future in a globalized world filled with uncertainty and instability. While the practice of KB has been seen as women's concern, incentives now exist for men to ensure fertility is controlled, as was shown in the narratives by two men in the previous section. People are also more aware of conditions outside of Indonesia as some migrate to Malaysia and neighboring countries to work. This suggests that their local environment is now more exposed to this globalized world and hence people's concept and expectations of family planning will also change. KB, hitherto a local term for family planning, is bound to be a more culture-free package of contraceptive knowledge and skill, as living conditions change. KB will no longer be the manifestation of a national policy but become a more neutral contraceptive technique in which both genders are able to control their fertility.

The Paradox of KB

The research illustrates contradictions between what the BKKBN claims in public and what women were actually experiencing. First, the Chairman of BKKBN, Haryono Suyono, stated in his speech in 1994 that KB is for everybody. He said, ‘The Indonesian program is based upon a premise that family planning should be everybody’s business – not just that of the government body formally charged with this task and a few related NGO’s. "Everybody" really means "everybody"' (Suyono 1994:24). Contrary to his statement, KB targeted women disproportionately to men and of these only married women were included in the program, with the total exclusion of unmarried women. KB was never everybody's business. Second, Suyono emphasized the role played by women saying, ‘In every village and sub-village, there is a hierarchy of volunteers – 99% of them are women – who plan, implement and evaluate the program’s activities.’(Suyono 1994:23). It is true that women played significant roles as implementers, recruiters and most importantly acceptors of KB. Considering women’s multiple roles in the program, it is unfair to highlight only their implementing and evaluating roles, as they were also the ones who accepted KB with its hormonal effects and health risks. By emphasizing
one aspect of the women’s role in the program, his comments overstate the image of empowered women. In fact, Suyono’s above statement which is published as a paper, comes under the section of female empowerment but this obscures the involvement of women in KB as victims. Third, Haryono Suyono states that people will realize the beneficial result of family planning; that is, if people become acceptors of KB, their lives would improve (Suyono 1994:21). As mentioned earlier, people opted for KB not because they felt their lives were improving but because they felt the need to limit the number of children due to the difficult economy and their lack of satisfaction in life. The initial ideal of prosperous life with the practice of KB gave way to a harsh reality which in turn created sustainable motives for KB.

Examining family planning in the detailed context of Indonesia brings about a more exact understanding of when and how it is beneficial for women, and when it is not. The women here have tried to transform their bodies to the bodies of wives which are characterized as having controlled fertility. This control can be ambivalent, as it is a power both to suppress and empower women. In the initial stages of KB, the source of power came from the government, but once the ability to control fertility was acquired by women, it was women themselves who could use the power to make their own decisions in life. In this sense it can be said that KB both undermines and benefits women’s empowerment. To conclude, by disseminating ideas of how men and women should be in their reproductive period and through its actual practice, KB constructs gendered body and gendered living in Indonesia.

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